

FILED SEP 14 1943

Registration District No. 200

Primary Registration District No. 2725

State File No.

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Macon
(b) City or town macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Steel-Hebrath O.S. San.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community In S.H.O.S. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pulaski
(c) City or town Waynesville
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Mrs Martha Hardison

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 185-9 years

7. Birth date of deceased. Feb 8 (Month) 185-9 (Day) (Year)

8. AGE: Years 84 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Dallas Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation at Home

11. Industry or business

12. Name Madison Stafford

13. Birthplace Lynn (City, town, or county) (State or foreign country)

14. Maiden name Pauline Maddy

15. Birthplace Lynn (City, town, or county) (State or foreign country)

16. (a) Informant Roy L. Hardison

(b) Address Springfield Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/22/43 (Month) (Day) (Year)

(c) Place: burial or cremation Union Mount Cem

18. (a) Signature of funeral director Robert S. Krumm

(b) Address Macon Mo

19. (a) 9/1/43 (Date received local registrar) (b) W. R. Trunkle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1943 hour 11 minute 30 PM

21. I hereby certify that I attended the deceased from Aug 19 1943, to Aug 21 1943; that I last saw her alive on Aug 21 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis Duration 20 yrs

Due to Arterio Sclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) 930

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury 2

23. Signature Anna L. Mauck (M.D. or other) MD

Address Macon Mo Date signed Aug 22

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-43-1567

Date Filed SEP 14 1943

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No.

working under my personal supervision.

Signed

Robert Skuman

Licensed Embalmer No.

75-1

P. O. Address

Macon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

ALBANY DISTRICT HEALTH OFFICER

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No. 5725

Registrar's No.

EC-107D

MANEN

GRUE PLAINLY—199 INKING BLACK INK—MAG 3

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon Hudson
(c) St. Libret
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town Rural Top
(d) Street No.....
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MARTHA HARDISON

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Feb 8 1884
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 3 If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9/18/43 (b) Jora B. Hunkle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13 year 1943 hour 3 minute 31 M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

28725